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FOR ACTION

RECOMMENDATIONS FOR FUNDING FOR SHORT-DURATION COUNTRY PROGRAMMES
IN THE EASTERN AND SOUTHERN AFRICA REGION*

SUMMARY

The present document contains recommendations for funding from general resources and supplementary funds for country programmes in the Eastern and Southern Africa region with a duration of three years or less that support activities in countries where full-length country programmes are under preparation. The Executive Director recommends that the Executive Board approve the following amounts from general resources, subject to the availability of funds, and the following amounts in supplementary funds, subject to the availability of specific-purpose contributions, for the country programmes listed below:

<u>Country/programme</u>	<u>Amount</u> (United States dollars)		<u>Duration</u>
	<u>General resources</u>	<u>Supplementary funds</u>	
Angola	3 200 000	6 700 000	1996
Sao Tome and Principe	750 000	345 000	1996
Somalia	3 000 000	23 000 000	1996

Summaries of individual recommendations follow.

* In order to meet documentation deadlines, the present document was prepared before aggregate financial data were finalized. Final adjustments, taking into account unspent balances of programme cooperation at the end of 1994, will be contained in the "Summary of 1995 recommendations for general resources and supplementary funding programmes" (E/ICEF/1995/P/L.10 and Add.1).

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I. ANGOLA

Basic data (1993 unless otherwise stated)

Child population (millions, 0-15 years)	5.1
U5MR (per 1,000 live births)	292
IMR (per 1,000 live births)	170
Underweight (% moderate and severe)	..
Maternal mortality rate (per 100,000 live births) (1994)	..
Literacy (% male/female) (1990)	56/29
Primary school enrolment (% net) (1991)	41
Primary school children reach grade 5 (%) (1990)	34
Access to safe water (%) (1991)	41
Access to health services (%) (1980)	30
GNP per capita (1992)	a/
One-year-olds fully immunized against:	
tuberculosis:	53 per cent
diphtheria/pertussis/tetanus:	30 per cent
measles:	47 per cent
poliomyelitis:	28 per cent
yellow fever:	32 per cent
Pregnant women immunized against:	
tetanus:	14 per cent

a/ Estimated to be lower-middle-income (\$676-\$2,695).

The situation of children and women

1. The single most important factor affecting the situation of children and women in Angola has been the intensification of civil war between 1992 and 1994. During that time, there have been more deaths and destruction of basic health, education and commercial infrastructures than during the past 18 years of civil war. The situation of children and women has never been as low. The national economy is in a crisis.
2. Seventy-five per cent of the cold chain are inoperable, while 60 per cent of health infrastructures have been destroyed or damaged. More than 25 per cent of classrooms are unusable due to the destruction of schools. Jointly, the battles of Huambo and Kuito contributed to the deaths of more than 50,000 persons. In Kuito, about four persons have died per day due to land-mines, and many are left maimed.
3. War, economic decline and collapsed social services have led to an alarming rise in the mortality of children and women. The infant mortality rate (IMR) and the under-five mortality rate (U5MR) are estimated to have risen from 173 and 292 per 1,000 live births, respectively, in 1991, to approximately 195 and 320, respectively, in 1994. In 1990, the maternal mortality rate (MMR) was 600-800 per 100,000 live births and it is estimated to have increased to 1,500-1,800. These mortality trends are evident in urban and peri-urban areas, but rural areas have similar patterns.

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4. The high mortality rates are due in part to the prioritization of governmental allocations for the military effort to the detriment of basic social services. In addition, children and women, fleeing to safety, lose access to basic social services, are killed by fighting or landmines, or die from acute respiratory infections (ARI), malaria, diarrhoea, cholera, measles, meningitis or polio. Malnutrition also kills many children. The highest levels of malnutrition, ranging from 35 to 65 per cent, were registered in 1993 and 1994. Under-five malnutrition reached 75 per cent in some locations. More than 2.5 million persons, mostly children and women, are affected directly by iodine deficiency disorders (IDD), and in the central highlands, goitre prevalence rates range between 50 and 73 per cent.

5. There are more than 12 million land-mines of different types. It would take an infinite period of time to make the country free of mines. More than 70,000 persons have lost limbs because of mines.

6. Since early 1994, the number of internally displaced persons has risen from 950,300 to 1.2 million. The population affected by the civil war has risen in the same period from 3.2 million to 3.7 million. About 68 per cent, or 2,516,000, of the war-affected population are comprised of children and women. Some 300,000 Angolans have sought refuge in Zaire and Zambia.

7. One visible consequence of civil war has been urban congestion and rural depopulation. Most cities are experiencing steadily deteriorating health, hygiene and sanitation standards, which often contribute to the onset of epidemics and create a strain on basic services. In Luanda, for instance, the population, most of whom live in deplorable conditions, has risen from about 1.6 million in 1991 to approximately 2.3 million as of mid-1994.

8. The growing number of street children, estimated at 4,000 in Luanda alone, is another visible consequence of the war, displacement and rapid urbanization. These children are hungry, malnourished, physically and sexually abused, sick, abandoned by their parents and families, subject to early military conscription, out of school and traumatized by war and the disintegration of family structures.

9. Although Angola has undertaken many economic reforms since 1991, economic performance still remains poor. The high dependence on oil and diamond revenues contrasts sharply with low productivity in other sectors of the economy. Annual inflation is more than 100 per cent, and between 1993 and 1994, the national currency was devalued by almost 1,000 per cent. Government salary levels have not kept up with inflation, leading to high absenteeism, low motivation and low productivity. Poverty is clearly visible in urban areas. Although its extent in many rural areas is unknown, there is little doubt that rural poverty is widespread.

Programme cooperation, 1991-1995

10. The 1991-1995 programme of cooperation was prepared at a time when a negotiated peace settlement for Angola seemed probable. The principal goals of the programme were to improve the situation of children and women through services aimed at reducing morbidity and mortality, improving nutritional status and strengthening the physical, social and intellectual development of young children. Provincial-level implementation of activities was a major strategy, as was the continuity of emergency-based actions to complement long-term development priorities.

11. The signing of the Bicesse Peace Agreement in May 1991 created conditions for very positive programme implementation with the Government and non-governmental organizations (NGOs). Growing accessibility to almost all parts of the country facilitated an increase in vaccination coverage to about

70 per cent in provincial capitals. About 1,500 essential drugs kits were distributed so that approximately 200 health posts and health centres were able to provide basic preventive and curative health services to peri-urban and rural populations. Similarly, more than 2,000,000 people benefited from combined household food security and relief and survival assistance. Important advocacy and development activities produced key achievements such as the ratification of the Convention on the Rights of the Child and the National Round-table on Education for All.

12. However, safety and security problems, leading up to the post electoral crisis, were a setback to programme implementation. In August 1992, key NGO and government officials began to flee from rural areas, and by September 1992, the gains achieved between May 1991 and August 1992 were being jeopardized. Following the "War of the Cities" from October to December 1992, and the evacuation of all UNICEF non-essential international staff from Luanda to Windhoek, Namibia, the activities of the Government, UNICEF, international NGOs and other United Nations agencies declined. For example, measles coverage appeared to have dropped from 70 to 60 per cent by the end of 1992. Whereas more than 2,000,000 people were assisted with seeds, tools, relief and survival items by the end of 1992, less than 1,400,000 people benefited from this assistance in 1993.

13. In early 1993, the programme was adjusted so as to be more responsive to the growing needs of millions of children and women who became vulnerable to armed conflict. Through two successive 90-day plans of action and a subsequent six-month plan of action, the Government and UNICEF refocused programme strategies to make humanitarian assistance the top priority. As of early 1994, 80 per cent of UNICEF assisted activities were for emergency services, while the remaining 20 per cent focused on development activities.

14. Significant progress has been made since the programme was adjusted. For example, UNICEF assistance to the Government and NGOs was instrumental in the vaccination of 963,000 children under the age of five years against measles and 905,000 women against tetanus; nutrition rehabilitation care reached 129,000 children; more than 2 million displaced and highly vulnerable persons received relief, seeds and tool kits; improved access to safe water benefited 643,000 persons in rural, peri-urban and urban areas; and 574 urban and peri-urban families received latrines.

15. UNICEF supported a programme called the "Grand Alliance for Life", comprised of a series of complementary and intersectoral activities to improve the well-being of women and children. The services included measles plus (with other health services), the control of IDD, universal salt iodization, the control of diarrhoeal diseases (CDD), acquired immune deficiency syndrome (AIDS) awareness, mines awareness and avoidance, polio eradication, psycho-social trauma and street children and peace education.

Lessons learned

16. The last major Government/UNICEF annual review of the country programme was undertaken in 1991. Nevertheless, abbreviated programme reviews were undertaken prior to adjustments in 1993 and during the third quarter of 1994. In the current country situation, improved delivery of basic social services for children and women can evolve, with a strong and active presence of UNICEF at the provincial level. Moreover, NGOs are key partners in programme implementation. However, this partnership generates better results when NGOs do not simply view UNICEF as a supplier of basic goods, and when UNICEF does not see NGOs as merely a vehicle for implementation. When both partners view each other as having important roles in policy and programme development, the partnership is at its strongest.

17. Some of the decade goals can be pursued with an effective mixture of geographical accessibility and government commitment and capacity. For example, the mid-decade goals for measles, vitamin A, iodine deficiency and diarrhoeal diseases are being pursued because the Government has committed resources and personnel, and itself advocates for their achievement. As a corollary, the sanctity of humanitarian assistance needs to be fully respected and guaranteed by all parties so that human misery can be averted even in times of protracted armed conflict.

18. The rehabilitation of large-scale infrastructures such as schools, hospitals and city water supply systems was pursued, but rehabilitation is an endeavour in which UNICEF should play a minor supportive role rather than a major one. UNICEF efforts should be complementary to those of other donors and focus on advocating for donor involvement in major rehabilitation programmes.

19. The field office structure introduced in 1993 as part of the programme adjustment greatly facilitated programme implementation. Drawing on the positive expansion efforts undertaken in late 1993, the field office structure has been reorganized so as to generate a high implementation rate through the decentralization of activities to the provincial levels. Twelve field offices are organized into seven clusters which facilitate programme implementation in 18 provinces.

20. Government salaries are low, which, in turn, forces civil servants to seek additional income; this constrains the capacity of Government to handle workloads. The resulting shortfalls in productivity for the Government could be largely averted through continuous capacity-building, together with administrative, social and economic reforms.

Recommended programme cooperation, 1996

Estimated annual expenditure

(In thousands of United States dollars)

	<u>1996</u>
<u>General resources</u>	
Primary health care	530
Nutrition	400
Water supply and sanitation	400
Education and children in especially difficult circumstances	500
Basic services development	310
Information and social communication	200
Social statistics, monitoring and evaluation	110
Programme management and support	<u>750</u>
Subtotal	<u>3 200</u>
<u>Supplementary funding</u>	
Primary health care	4 500
Nutrition	500
Water supply and sanitation	1 000
Education and children in especially difficult circumstances	500
Social statistics, monitoring and evaluation	<u>200</u>
Subtotal	<u>6 700</u>
Total	<u>9 900</u>

Objectives

21. A one-year country programme for 1996 is required to bridge the end of the current country programme (1991-1995) and to support the preparation of a new cycle. A 1997-2001 programme cycle is planned, should the country situation permit. A bridging programme in 1996 will give both the Government and UNICEF sufficient time to adequately plan a 1997-2001 country programme and to harmonize programme cycles with the United Nations Development Programme (UNDP) and the United Nations Population Fund (UNFPA).

22. The objective of the 1996 bridging programme is to establish a framework for sustainable reductions of infant, under-five and maternal mortality. The bridging programme will attempt to benefit from the expected positive results of the peace process during 1995. Humanitarian assistance, together with support for a comprehensive demobilization and reintegration process, will be a major programme strategy during 1995. If gains for peace in 1995 can be sustained, a successful bridging operation should take place in 1996. Otherwise, the 1996 bridging will need to be refocused accordingly.

Strategies

23. Three existing strategies will be pursued: (a) emergency service delivery with relief, rehabilitation and development activities; (b) capacity-building; and (c) advocacy for social sector reform. These strategies are fully applicable to the objectives of the bridging programme and supportive of the peace process.

24. The strategy for emergency social services combines responses to the immediate needs of children and women with the underlying causes of their vulnerability. For example, there is complementarity between short-term assistance to families exposed to armed conflict and medium- to long-term support for the restoration of basic social services and the promotion of household food security.

25. The development of national capacities and international support, targeted principally at enhancing skills to plan, implement, monitor and evaluate programmes, is also a major strategy. Inadequate budgetary allocations to the social sectors will be addressed through policy advocacy on poverty reduction and sustainable human development. UNICEF, in close collaboration with other partners, will support dialogue and analysis on social sector reform.

26. The bridging programme will comprise primary health care (PHC), nutrition and household food security, water supply and sanitation, education and children in especially difficult circumstances. While pursuing sector-specific strategies, each of the programmes will be guided by the overall programme strategies identified above. The sectoral objectives are basically a continuation of those which were not fully achieved during the 1991-1995 country programme.

Primary health care

27. The focus of the PHC programme is the reduction of infant, under-five and maternal mortality, as well as the achievement of key mid-decade goals. The priority strategies are the revitalization of basic maternal and child health (MCH) and health services; the protection of children against expanded programme on immunization (EPI) diseases; the promotion of the safe motherhood initiative; the control of communicable childhood diseases, including malaria; the provision of sufficient quantities of essential drugs; and national capacity-building for programme development and implementation. UNICEF will assist activities for vaccination at fixed posts and during campaigns; the distribution of drug kits and packets of oral rehydration salts; the training of health care workers in integrated PHC; and operational health research and baseline studies.

Nutrition

28. The objectives of the programme are to reduce morbidity and mortality related to acute and chronic malnutrition in young children; to provide nutrition surveillance and growth monitoring; to reduce the incidence of micronutrient deficiencies; and to promote subsistence farming among displaced and vulnerable farmers. The programme is composed of four projects: improved child growth; nutrition surveillance; micronutrient deficiency diseases; and capacity-building. UNICEF will assist the promotion of breast-feeding and the establishment of "baby-friendly" hospitals; implementation of a nationwide nutrition survey; the procurement and distribution of nutrition surveillance and monitoring supplies; salt iodization; and training for nutritionists.

Water supply and sanitation

29. The water supply and sanitation programme seeks to strengthen national government capacities for improved planning, implementation and sustainability of water supply and sanitation facilities; to improve the control of hygiene-related diseases; and to restore and provide water supply and sanitation facilities in underserved and emergency areas. The programme is comprised of three projects: institutional capacity-building; integrated provincial hygiene, sanitation and water supply; and emergency service. The creation of new and the rehabilitation of old water points and systems, latrine construction and the promotion of integrated hygiene and sanitation are major activities.

Education and children in especially difficult circumstances

30. The objectives are to increase educational opportunities for out-of-school children and to improve the quality of teaching in peri-urban and rural areas; to increase alternative opportunities for the care and education of children in especially difficult circumstances; and to promote the increase of education and income-generation opportunities for peri-urban and rural women, particularly among displaced and resettled groups, and the poor. The five projects are: primary education; early education; children in especially difficult circumstances; human rights and peace development; and women's development and gender issues. The range of activities include the provision of technical support to government and NGO personnel; the provision of teaching/learning kits; the formulation of appropriate pedagogical policies and legislation; and the development of media messages.

Basic services development

31. Basic services supported by well-coordinated social communication, monitoring and evaluation will improve humanitarian assistance to war- and drought-affected populations, especially displaced children and women. The strategy will be to achieve high coverage of priority programmes and to assist with the reintegration of affected families and individuals. Other strategies include institutional capacity-building such as joint planning with all partners; the rehabilitation of basic social services; and the development of community-based interventions. Activities will focus on providing needy families with seeds, tools, and relief and survival items; conducting needs assessments; developing provincial implementation plans; and facilitating interventions of technical sectors at the provincial level.

Information and social communication

32. The role of information and social communication is to increase and disseminate child survival and development (CSD) information for positive behavioural changes among children and women. Another role is to promote awareness of national and international groups on child rights. The sector will implement four projects during the bridging period: (a) information and

advocacy; (b) social communication; (c) mine awareness and avoidance; and (d) human immunodeficiency virus (HIV)/AIDS behavioural change. Activities will include information campaigns; materials development; the promotion of information, education and communication (IEC) strategies on survival needs and child rights; the empowerment of beneficiary groups; the mobilization of national and international partners; implementation of knowledge, attitude and practice surveys; training in graphic design; and the development of a resource mobilization strategy.

Social statistics, monitoring and evaluation

33. Strengthened programme information and assistance to the Government and NGOs in the collection, analysis and dissemination of essential statistics and research on children and women is the objective. Three projects are included: monitoring the impact of the Angolan economy on children and women; social statistics data collection; and programme monitoring support. Activities will include the design and implementation of low-cost surveys and data collection techniques; operational research and evaluations; the wide dissemination of essential statistics; needs assessment missions; and advocacy on behalf of social sector reform.

Cooperation with other partners

34. To support the United Nations country programme harmonization process, UNICEF will continue to work closely with other United Nations agencies in developing a joint situation analysis and a country strategy note, the preparation of which was deferred while awaiting peace and stability. Sustainable human development, social sector reform, capacity-building and humanitarian assistance will be pivotal issues in the country strategy note.

II. SAO TOME AND PRINCIPE

Basic data (1993 unless otherwise stated)

Child population (millions, 0-15 years)	0.1
U5MR (per 1,000 live births)	84
IMR (per 1,000 live births)	64
Underweight (% moderate and severe) (1986)	17
Maternal mortality ratio (per 100,000 live births) (1991)	79
Literacy (% male/female) (1981)	73/42
Primary school enrolment (% net, male/female)	82/81
Primary school children reaching grade 5 (%) (1985)	88
Access to safe water (%)	74
Access to health services (%) (1985)	80
GNP per capita (1992)	\$360
One-year-olds fully immunized against:	
tuberculosis:	77 per cent
diphtheria/pertussis/tetanus:	60 per cent
measles:	57 per cent
poliomyelitis:	60 per cent
Pregnant women immunized against:	
tetanus:	42 per cent

The situation of children and women

35. Despite a gross national product per capita of only \$360, Sao Tome and Principe's overall health situation is better than most countries in the region. IMR is 64 per 1,000 live births. About 45 per cent of the 1,000 deaths registered annually occur among children under five years old. The principal causes of under-five deaths are malaria, ARI and anaemia. MMR is officially 79 per 100,000 live births, but it is probably under-reported.

36. The most common cause of morbidity for all age-groups is malaria. Malaria control activities are being implemented through a World Bank project. After malaria, the most common diseases among children are helminthiasis, anaemia, ARI and diarrhoeal diseases. The number of AIDS cases was 13 by the end of 1993.

37. Although more recent information is not available, 1986 figures suggest that 17 per cent of children under five years old suffer from moderate or severe malnutrition, particularly in the southern region. Vitamin A deficiency has never been reported. In 1993, a survey on goitre prevalence among schoolchildren confirmed that IDD is a problem and should be addressed through the iodization of salt. The overall goitre rate was 50 per cent, with the highest rate in the southern district of Caue. There was no iodized salt available in the markets. Hospital data from 1992 suggest a prevalence of low birth weight of 10 per cent. No official data exist on anaemia during pregnancy, but there is concern that food taboos may represent a major cause.

38. The number of health facilities is adequate despite a reduction in the second half of the 1980s. Most of the health units are simple first aid posts, located in poorly maintained buildings, with limited equipment and poorly trained and motivated staff. The quality of the services is often inadequate,

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compounded by poor communication and transport facilities, particularly in rural and peri-urban areas.

39. After achieving universal child immunization for all antigens in 1991, immunization coverage decreased substantially owing mainly to the sharp increases in fuel prices which hampered the activities of mobile teams. Figures from the first quarter of 1994 show that the downward trend has been halted and 1994 coverage figures are expected to be substantially higher than in 1993.

40. A large majority of the population are aware of oral rehydration therapy (ORT), its preparation and use. However, ORT use is rare in rural areas. Roots and leaves are widely used, while in urban areas, antibiotics and anti-diarrhoeals continue to be the most common treatment.

41. Twelve per cent of women of child-bearing age use family planning methods. Two thirds of pregnant women attend antenatal clinics, but only 50 per cent of pregnant women receive two doses of tetanus toxoid. Sixty per cent of deliveries are assisted in health institutions, a decline of 15 per cent from the second half of the 1980s.

42. Neither local production nor imports ensure a sufficient supply of food and, consequently, there are periodic shortages of basic food items. The monoculture of cocoa limits household food security. The 1991 national census suggests that 15 per cent of households lack sufficient income. Eight out of 10 of these households are headed by women. A 1990 study found that 33 per cent of these households live in extreme poverty.

43. The educational system is deteriorating in terms of school infrastructure and equipment, particularly pre-schools and primary schools. The shortage of teaching materials, poorly trained teachers (43 per cent of primary school teachers and 83 per cent of secondary school teachers) and the lack of motivation constitute major problems. As a result, the quality of education is poor, with significant failure and drop-out rates. Net primary school enrolment exceeds 80 per cent without significant gender disparity. Pre-school enrolment is only 40 per cent owing mainly to limited space. Street children are becoming an important phenomenon in Sao Tome town.

44. Low coverage and poor quality of environmental sanitation services contribute to morbidity and mortality among children and women. In 1993, only 25 per cent of the population had access to sanitary means of excreta disposal, while 74 per cent had access to safe water. Even with low access, sanitation improved slightly after 1990 due to a successful latrine/health education project, with active community involvement.

45. The country does not yet have a national development plan. The national programme of action (NPA) for children was completed in June 1994. The Convention on the Rights of the Child was ratified in May 1991. Many national NGOs have been formed in the last few years and they are particularly active in the areas of street children, health education, environmental protection and social mobilization.

Programme cooperation, 1991-1995

46. The 1991-1995 Government/UNICEF programme of cooperation focused on MCH, the provision of safe drinking water, sanitation, pre-school and primary education, community development and street children. The major objectives were to reduce IMR and U5MR and to improve the quality of life of children and women, with an emphasis on health, nutrition and education.

47. The objective of the health programme was to reduce morbidity and mortality among children under five years old and pregnant women and to promote CSD by increasing coverage, quality and access to PHC. Refresher courses were held for 100 community health workers (CHWs) and 250 health activists. Emphasis was given to EPI mobilization and the protection and maintenance of drinking water sources.

48. The overall objectives of the education programme were (a) the development of services for life skills for young children and youth through interactive radio instruction; and (b) primary school teacher training, using low-cost solutions involving the participation of the community. The main achievement was the training of primary school teachers from all seven districts.

49. The area-based integrated development programme concentrated on child survival, protection and development and the promotion of women at the community level. Community-managed activities were supported by interventions such as the provision of safe drinking water and the construction of latrines. Latrines were built for 1,000 households, and 35 water sources were protected. In addition, IEC materials on health education also were developed. Between 1990 and 1993, there was an 11 per cent increase in access to water and an 8 per cent increase in access to latrines.

50. Implementation of the country programme was hampered by several constraints. A health cost-sharing mechanism based on the Bamako Initiative failed partly due to a virtually non-existent tradition of community participation and insufficient management capacity due to a shortage of trained personnel. There have been cutbacks in the social sector budgets under the structural adjustment programme. Lastly, national development priorities are generally not clearly expressed, and planning is hindered by a lack of reliable data.

Lessons learned

51. The mid-term review took place in October 1993 and analysed achievements and constraints and identified priorities. The need to strengthen community involvement in planning, cost-sharing and project implementation to sustain and improve the quality of social service delivery was identified. Better coordination and information-sharing among all participating agencies is also required. Training at all levels requires greater support and careful planning. Training of CHWs and primary school teachers as well as the latrine project are considered "success stories" which should be replicated on a wider scale.

Recommended programme cooperation, 1996

Estimated annual expenditure

(In thousands of United States dollars)

	<u>1996</u>
<u>General resources</u>	
Primary health care	200
Basic education	130
Integrated basic services	170
Programme support	<u>250</u>
Subtotal	<u>750</u>
<u>Supplementary funding</u>	
Primary health care	115
Basic education	95
Integrated basic services	<u>135</u>
Subtotal	<u>345</u>
Total	<u>1 095</u>

Objectives

52. The current UNICEF programme cycle, which ends in 1995, was to be followed by a new programme covering the period 1996-2000. However, the UNDP and UNFPA programme cycles run from 1997 to 2001. Therefore, with the objective of harmonizing programme cycles with UNDP and UNFPA, a one-year programme in 1996 would bridge the current programme, with a five year programme beginning in 1997.

53. In this context, the main objective of the 1996 bridging programme will be to establish the groundwork for sustainable reductions in IMR, U5MR, MMR and child malnutrition. Proposed rates of reduction will be presented in quantifiable terms in the country programme recommendation for the 1997-2001 cycle.

Programme strategy

54. The coverage of the programme of cooperation will be nationwide, with particular attention to socio-economically disadvantaged areas. The priority target groups for the country programme will be children under five years old, children who are achieving poor results in school, children who have difficult access to school and health facilities, street children and pregnant women. The NPA, the World Summit for Children goals and the Dakar Consensus will be used as frameworks to plan, monitor and evaluate activities and for advocacy purposes. Efforts will be made to reduce the social disparities between boys and girls and between men and women. An integrated approach to decentralize planning and decision-making, with community participation, will be promoted.

Primary health care

55. The objectives of the health programme are to eliminate all immunizable diseases, iodize all salt consumed in the country and reduce morbidity and

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mortality caused by diarrhoeal diseases, ARI and malaria. The programme is comprised of three components: MCH; support for the national health system; and training.

56. UNICEF will provide technical, logistical and financial support for activities in the areas of EPI, CDD, ARI, salt iodization and MCH. Priority will be given to supporting an advanced, stationary health post approach for EPI; promoting the integration of health services with EPI; and promoting the Baby-Friendly Hospital Initiative in health centres that are equipped to assist in deliveries. Social mobilization for health at all levels will be strengthened by capacity-building in communication skills and health education techniques. Support also will be provided for initiatives to improve monitoring capacity and promote inter-agency and intersectoral cooperation.

Basic education

57. The objectives of the basic education programme are to improve the performance of primary school children and to increase access to a better standard of teaching for pre-school and primary school children.

58. UNICEF will assist the Ministry of Education in the local production of relevant teaching materials for pre-schools and primary schools. Activities include the training of primary school teachers in health education, participatory radio instruction, physical education and handicraft skills; and advocating the integration of these activities into the school curriculum. Support will be provided to communities in initiatives for basic rehabilitation of pre-schools and primary schools. Advocacy will focus on the formulation of a new basic education law and a new school health programme which includes preventive interventions on sexually-transmitted diseases and HIV/AIDS. Lastly, in line with the Convention on the Rights of the Child, advocacy will address the needs of the girl child, disabled children and street children.

Integrated basic services

59. The objectives of the integrated basic services programme are to expand the network of basic services managed by the communities, particularly water supply and sanitation services; and the promotion of behaviour that is favourable to child health.

60. UNICEF will support the process of decentralization of decision-making, in line with Government policy, by assisting community mobilization activities in all four programmes. Other activities will include the local development of low-cost health education materials and the development of a community-based data collection system, using the sentinel surveillance approach. In order to achieve universal access to safe water and sanitation facilities, strong emphasis will be given to neglected geographical areas.

Programme support

61. Programme support is aimed at strengthening planning, implementation, management, monitoring and evaluation. Other objectives include the integration of human development priorities, especially women and children, into the planning and implementation of national development policies and implementation of the NPA.

62. Activities will include increasing efficiency at all levels in the planning, management, monitoring and evaluation of projects for women and children. Through advocacy and social mobilization, efforts will be made to prioritize the needs of women and children. This programme will be implemented with NGOs and other local organizations.

Monitoring and evaluation

63. The monitoring and evaluation of the programme of cooperation will be the responsibility of ministries, district authorities, beneficiaries and UNICEF. Frequent field visits will be undertaken to monitor closely project activities and to identify achievements and constraints. An annual review meeting of all programmes and projects will be held between the Government and UNICEF, with the participation of NGOs. The country strategy note for United Nations cooperation in Sao Tomé and Príncipe is expected to be finalized by 1996 prior to the adoption of the national development plan.

Coordination with other agencies

64. The programme of cooperation requires the cooperation of United Nations agencies, national and international NGOs and other partners providing technical assistance to various components of the programme where common objectives have been identified and to ensure the maximum use of limited resources. Close cooperation will be maintained with UNDP in the area-based programme, the World Health Organization (WHO) for AIDS prevention, the World Food Programme (WFP) to assist street children, and the United Nations Population Fund (UNFPA) for family life education, the World Bank in malaria control and the African Development Bank in school rehabilitation. In addition, the European Union will be rehabilitating the capital city water system, which is highly complementary to UNICEF-supported activities. All United Nations agencies are cooperating with the Government to prepare the country strategy note.

Programme management

65. Programme management will remain the responsibility of the Government through the Cooperation and Development Department of the Ministry of Foreign Affairs and Cooperation, which will be responsible for overall coordination. Coordination of activities within each sector will be the responsibility of the respective ministry. The Ministry of Health will be responsible for the PHC and integrated basic services programmes, while the Ministry of Education will be in charge of the basic education programme.

III. SOMALIA

Basic data (1993 unless otherwise stated)

Child population (millions, 0-15 years)	4.7
U5MR (per 1,000 live births)	211
IMR (per 1,000 live births)	125
Underweight (% moderate and severe)	..
Maternal mortality rate (per 100,000 live births) (1981)	1,100
Literacy (% male/female) (1990)	36/14
Primary school enrolment (% net, male/female) (1985)	11/6
Primary school children reaching grade 5 (%) (1985)	52
Access to safe water (%) (1988)	37
Access to health services (%) (1983)	27
GNP per capita (1992)	a/
One-year-olds fully immunized against:	
tuberculosis:	31 per cent
diphtheria/pertussis/tetanus:	18 per cent
measles:	30 per cent
poliomyelitis:	18 per cent
Pregnant women immunized against:	
tetanus:	5 per cent

a/ Estimated to be low-income (\$675 or less).

The situation of children and women

66. The situation of children and women in Somalia is shaped by continuing civil war and turmoil. The absence of Government, law and order, and public funds to support basic services means that there is virtually sole reliance on indigenous voluntary efforts and external assistance for improving child survival, development and protection. Already, Somalia had depended on external assistance long before the start of civil war. United Nations and bilateral assistance during the last two years have been very substantial. After two years of a large United Nations presence for peace-keeping, the restoration of political order and justice and humanitarian assistance, the United Nations Operation in Somalia (UNOSOM) will have withdrawn by end-March 1995. The impact of this withdrawal, and the realities of the post-UNOSOM era, are largely unpredictable.

67. The stalemate in negotiations for peace among political factions in Somalia and the insecurity and banditry that have worsened with the prolonged absence of Government have created a massive human tragedy. Even when political reconciliation takes place, the creation of an effective, national administrative system will take a substantial amount of time. Hence, basic services for children and women will continue to be dependent on external assistance during the process of revitalizing local institutions and communities.

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68. There is an absence of reliable statistical data on the situation of children and women. Therefore, a trend analysis is not possible with respect to goals for children.

69. Although national figures are not available, UNICEF estimates that MMR remains alarming; IMR and USMR are still unacceptably high, and the nutritional situation of children and mothers, despite improvements through feeding programmes, remains precarious. The majority of Somalis are still deprived of safe water, a sanitary environment and access to basic education. The sustainability, let alone expansion, of basic services for children and women will depend on whether the structures for health, nutrition, education facilities and safe water continue to function. It is, therefore, important that more communities become able to support some services until local infrastructures can be rebuilt to sustain them.

Programme cooperation, 1994

70. UNICEF operated from five zonal offices with decentralized management, and cooperated closely with UNDP, WFP, WHO and the Food and Agriculture Organization of the United Nations, as well as with national and international NGOs such as Médecins sans frontières, Save the Children and Habitat International, among others. UNICEF also maintained close contact with bilateral organizations through regular briefings and sharing of monthly newsletters.

71. UNICEF assistance in health made it possible for some Somali children and women to have greater access to PHC. Against a target of 96 MCH centres, 119 centres are currently operating. To address the family health needs, UNICEF supported 74 out-patient units, 271 health posts and 19 hospitals. As of September 1993, child immunization coverage was 154,660 for anti-tuberculosis vaccine, 188,207 for combined diphtheria/pertussis/tetanus and oral polio vaccine and 97,934 for measles since the establishment of EPI in 1993. Tetanus toxoid vaccination covered 113,000 women of child-bearing age. UNICEF trained and equipped 550 CHWs and 192 traditional birth attendants, bringing the total number of health workers trained to 994.

72. For child and maternal nutrition, supplementary feeding was provided to 127,000 vulnerable children and women as of September 1994; 330,000 children received vitamin A supplementation. Iron supplementation was provided to 108,000 pregnant and lactating women.

73. Performance exceeded the 1994 targets in water supply, with the construction of 215 new wells and the rehabilitation of 8 large urban water systems, 12 bore holes and 380 shallow wells. These activities, and the regular chlorination of drinking water, benefited some 1.5 million Somalis throughout the country. UNICEF also provided assistance to control a widespread cholera epidemic in Somalia.

74. In basic education, UNICEF rehabilitated 44 schools. By September 1994, instructional materials had been provided to over 400 primary and Koranic schools against the year's target of 520. In addition, 1,389 primary and Koranic school teachers and heads of school were trained of a target of 1,400. These activities have benefited 120,000 children country-wide. To address the psycho-social needs of children and women traumatized by war, UNICEF trained 40 teachers, 10 Imams (religious leaders) and 35 health workers. In education, 3,188 women were trained in literacy and skills for income generation.

Lessons learned

75. Given the current and prospective situation in Somalia over the next year, the programme strategy and decentralized UNICEF operations through the existing five field sub-offices, will be maintained. UNICEF will continue to cooperate

with other United Nations agencies and NGOs to support communities in the 18 regions and 96 districts selected. In order to manage the field sub-offices in the absence of law, security or normal commerce, UNICEF needs to continue to operate its own life-support systems, including air operations, office and residential security arrangements, adequate and essential telecommunications networks and living quarters. This will require strengthening of the field sub-offices, two supply staging points and the UNICEF Somalia Support Centre in Nairobi.

76. UNICEF needs to continue to cooperate with international and local NGOs for project implementation. An important lesson learned is that properly selected local NGOs, and those related to women's needs, should be involved increasingly in building Somali technical management capacity. NGOs also can support women's roles in the peace-making and peace-keeping processes.

Recommended programme cooperation, 1996

Estimated annual expenditure

(In thousands of United States dollars)

	<u>1996</u>
<u>General resources</u>	
Health	650
Nutrition	100
Water supply and sanitation	450
Education	100
Air operations	500
Programme support	<u>1 200</u>
Subtotal	<u>3 000</u>
<u>Supplementary funds</u>	
Health	6 720
Nutrition	1 150
Water supply and sanitation	4 060
Education	2 070
Planning, monitoring and evaluation	500
Air operations	1 000
Programme support	<u>7 500</u>
Subtotal	<u>23 000</u>
Total	<u>26 000</u>

Programme objectives and strategy

77. The current situation in Somalia does not allow for the development of a long-term country programme. Hence, this one-year bridging programme is being proposed. The country situation will be monitored closely to assess the scope for UNICEF assistance for 1997 and onwards. In the absence of formal Government in most regions, very strong community commitments are essential to permit UNICEF to deliver assistance. UNICEF will work with communities that provide security for UNICEF staff and operations. These communities are more likely to sustain their own successes with basic services.

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78. UNICEF will expand initiatives with each programme, while trying to consolidate and sustain achievements. Local capacity to maintain high recurrent costs for primary schools, feeding centres, MCH centres and health posts, which are normally government-funded, continues to be limited. Where possible, UNICEF will continue to support the organization of management boards and community committees in water supply, health and education to manage revenue collection systems and, where possible, initiate community financing schemes.

79. UNICEF will support the establishment of a core of basic services throughout Somalia. To do this, the 1996 programme will have three interrelated objectives. In relatively secure locations, community-based activities will be promoted for Koranic schools, primary education and safe water supply and environmental sanitation. Capacity-building and long-term sustainability will be major strategies. In locations where there are both stability and a functioning administration, UNICEF will promote the adoption of policies and budget allocations to promote the Convention on the Rights of the Child and the World Summit for Children goals. In communities where cohesion or security is low, UNICEF also will promote basic services such as immunization, ORT, safe drinking water, antenatal and post-natal care, and preventive and curative services for ARI and malaria.

80. Health units, particularly MCH centres, are critical for the delivery of basic survival services. Currently, existing centres are supported almost entirely by external assistance. Moreover, communities often give low priority to preventive health services such as immunization. To address this constraint, UNICEF will aim to integrate popular services, such as income-generating activities and water supply, with essential, less popular services such as MCH, so that more recurrent costs are borne by communities.

81. The demand for preventive services also will be increased by improving their quality and more effective public communication. As demonstrated by global experiences in PHC and community financing, these initiatives may require years to come to fruition. Therefore, while UNICEF will actively seek to develop community financing, it also will continue to support some recurrent costs. UNICEF will utilize supplementary funding for activities in health, education, water supply and sanitation, and programme support.

82. To respond effectively to rapidly changing situations, UNICEF will strengthen monitoring, operational research and the evaluation of programmes. There will be periodic, regionally-based monitoring of indicators, improved baseline data and more analysis of information to improve programme management. Operational research will cover important subjects such as performance of small loan funds, feasibility of cost-recovery and design of convergence of services.

83. Each year at least one sectoral and one regional programme will be evaluated to capture lessons that may not have been covered sufficiently by monitoring or operational research. This emphasis on research and evaluation will support the planning process for a 1997-2001 country programme which, if circumstances in the country permit, will require a comprehensive situation analysis. UNICEF will continue to conduct an annual review programme of assistance to analyse achievements and constraints as a basis for formulation of the subsequent year's programme.
